



LT MO I

CITY OF GARDNER**ACCIDENT/INCIDENT REPORTING AND TREATMENT FORM**
Public Safety Personnel

Name of Employee: _____ Social Security # ____ - ____ - ____ Date ____/____/____

Address: _____ City _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Department: ☐ Police ☐ Fire Position Title: _____

Date of Injury ____/____/____ Time ____ AM/PM Date of Birth ____/____/____

Name of Supervisor: _____ Title: _____

Wage Per Hour: _____ Average Weekly Earnings: _____

No. of Hours Worked Per Day: _____ No. of Days Worked per Week: _____

Scene of Accident/Incident: _____

Witness(es): _____

Describe What Happened, include substances, materials or vehicles involved, including nature of injury and body part affected: _____

I hereby authorize The City of Gardner (or any of its representatives), to be furnished any information and facts regarding this injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of the above incident and for no other purpose. A photocopy of this release shall serve and be as valid as the original. This release shall be valid until withdrawn by me in writing.

Signature of Employee _____ Date ____/____/____

Please complete Page 1 of form and return it to the Personnel Department. Should you require medical treatment, Page 2 of the form should be completed by your medical provider and returned with Page 1.



CITY OF GARDNER

OUTSIDE PROVIDER STATEMENT

Name of Employee: _____

Nature of Injury: New Injury No injury/illness found Recurrence/aggravation of existing injury

Type of Injury _____ Body part injured _____

Treatment: _____ Follow up (if any) _____ Date ____/____/____

Restrictions:

LIFTING	POSITIONS	PUSHING/PULLING
No lifting	No work requiring repeated stooping	Pushing or pulling with a
Lifting with a	No crawling, kneeling or cramped	Limit of 1 – 5 lbs
Limit of 1 – 5 lbs	Positions	Limit of 6 – 10 lbs
Limit of 6 – 10 lbs	No continuous walking or standing	Limit of 11 – 25 lbs
Limit of 11 – 25 lbs	to exceed 50% of total work time	Limit of 25 – 40 lbs
Limit of 25 – 40 lbs	No continuous sitting	Limit of 41 – 75 lbs
Limit of 41 – 75 lbs	DEXTERITY	No pushing or pulling
No reaching ABOVE shoulders	No exposure to vibrating tools	CLIMBING
No reaching BELOW shoulders	No constant fingering	No work requiring repeated
	No repetitive wrist motion	or frequent stair climbing

Other restrictions _____

Patient disposition

Return to Supervisor; no restrictions

Return to Supervisor with restrictions (above) for _____ days

Return to Supervisor; send home (employee can return to work _____)

Follow up appointment on _____ with _____

Medical Provider Signature _____ Date _____

Printed Name of Medical Provider & Address _____